

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034498

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 133Primary Registration District No. 3022Registrar's No. 127

FILED OCT 2 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Harrison		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Harrison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bethany		c. CITY OR TOWN New Hampton	
Length of stay in lb. 1 day		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Noll Memorial Hospital		d. STREET ADDRESS (If outside, give location) 4 mi. So. New Hampton	
3. NAME OF DECEASED (Type or print) First Charles Middle Leonard Last Baker		4. DATE OF DEATH Month Sept. Day 26 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/16/81
9. AGE (last birthday) 81		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (own farm)		10b. KIND OF BUSINESS OR INDUSTRY Farmer Rtd.	
11. BIRTHPLACE (City and state or country) Harrison Co. Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William H. Baker		13b. MOTHER'S MAIDEN NAME Luvina E. Meredith	
14. NAME OF HUSBAND OR WIFE Hazel Baker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No None	
16. SOCIAL SECURITY NO. 8		17. INFORMANT Address Mrs. Hazel Baker New Hampton, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Longestium heart failure DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 1-9-1961 to 9-26-1962 and last saw him alive on Sept. 26, 1962 . Death occurred at 3:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Albert J. Marshall M.D.		22b. ADDRESS Bethany, Missouri	22c. DATE SIGNED 9-27-62
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE 9/28/62	23c. NAME OF CEMETERY OR CREMATORY Foster Cemetery	23d. LOCATION (City, town, or county) Harrison Co. Mo.
24. FUNERAL DIRECTOR ADDRESS C. R. Noble New Hampton, Mo.		25. DATE RECD. BY LOCAL REG. 9-27-1962	26. REGISTRAR'S SIGNATURE Gella Mayes

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William George Vohle

Licensed Embalmer No. 4987

P. O. Address Bethany, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.